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AUTHOR Kurtz, Suzanne M.
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ABSTRACT

Recent communication training for health care clinicians has given little if any emphasis to systematic skills training in "giving" information to patients and others. The purpose of the communication unit presented to second-year medical students at the University of Calgary, Canada, is to enhance the clinician's ability to communicate effectively. The unit consists of four phases: (1) introduction, overview, medical interviews, and evaluation; (2) psychosocial issues and difficult situations; (3) giving information to patients, definitive counseling, and supportive counseling in specific "difficult situations"; and (4) giving specific information to patients, and integrating communication skills. The course establishes the value of viewing the giving of counsel to patients as a four-sided process that includes directive, advocacy, informative, and supportive counseling. A final three-part exercise gives students opportunity to observe and/or practice information-giving skills and to integrate the various communication tasks together into a whole: part 1 is an evaluation interview including a physical exam, part 2 is a small group problem-solving session, and part 3 is a planned individual counseling session observed by the rest of the class. During their third year, the students have considerable additional opportunities to observe and participate in patient evaluations, preliminary counseling, and definitive counseling. (HTH)

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A FORMAT FOR TEACHING INFORMATION GIVING SKILLS TO HEALTH CARE PROFESSIONALS

A Paper Presented at the 32nd Annual Conference
of the
International Communication Association
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Suzanne M. Kurtz, Ph.D.
University of Calgary, Alberta, Canada
Faculties of Education and Medicine

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Face-to-face communication is one of the most basic clinical skills. Clearly, it is significant in the development of a supportive and cooperative relationship between clinician and patient. Equally important is the fact that the quality of communication enhances -- indeed, determines -- the accuracy and efficiency with which a variety of clinical tasks are carried out. These tasks include, for example, gathering information about the physical and psychological well-being of patients, discussing impressions and findings with other health care professionals, informing patients about findings, reassuring patients and their loved ones, and counseling patients with regard to courses of action, treatments, and recommendations.

In recent years those responsible for the education of clinicians in health care have given increasing attention to communication training. However, as Carroll and Monroe (1980) and Kahn et al (1979) point out in their reviews of the literature, most communication training for clinicians focuses on building relationship with patients and gathering information from them. Little if any emphasis is given to systematic skills training in an equally significant area, that of giving information to patients and others. This paper outlines a systematic approach for teaching information giving skills to clinicians as part of a larger communication training program. Because it is important to view information giving skills training in context rather than as an isolated unit, the paper begins with an overview of the larger, four- part communication training program. The format for teaching infor mation giving is then described with respect to objectives, definition of terms, and suggested methods.

The program described here and the supplementary materials included with this paper were developed for the Communication Unit of the Clinical Skills Course, which is presented to medical students at the University of Calgary, Alberta. Training with respect to three kinds of skills is incorporated into the Communication Unit. Content skills have to do with what is communicated -- for example, the parts of a medical history, the specific questions one asks to follow up the patient's initial report of a symptom or problem, the material reported in the written record. Process skills have to do with how the content is communicated -- the way

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information is gathered or given, the way relationship is built, the way one initiates or terminates an interview, the organization, structure, pacing, and control of the interview. Conceptual skills have to do with personal thought processes -- synthesizing information; developing hypotheses, diagnosis, and plans for treatment; monitoring one's own content and process skills (and those of others). The objectives of the Communication Unit focus most directly on content and process skills. Attention given to conceptual skills per se is more indirect. Because of the purposes for which they were originally developed, the materials and ideas presented in this paper refer to medical students and medical history taking. Please note, however, that with some changes (particularly in the area of content skills) these materials and ideas are equally applicable to students who are training to become clinicians in any of the health care professions.

OVERVIEW OF THE COMMUNICATION UNIT

The purpose of the total Communication Unit is to enhance the clinician's ability to communicate effectively. But how does one select, make memorable, and organize into a coherent whole all the bits and pieces which contribute to effective communication in health care? Table 1 outlines the conceptual framework which begins to answer these questions and around which the unit is therefore organized.

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*Table 1: Considerations for Effective Clinical Communication

BROAD GOALS clinicians seek to accomplish during face-to-face interaction:

- Accuracy
- Efficiency
- Supportiveness

TASKS which clinicians carry out during any interaction:

- Initiating the interaction
- Gathering information
- Building relationship
- Giving information
- Terminating the interaction

TYPES OF INTERACTION which occur in health care (Tri-Level Model)

- Evaluation
- Preliminary counseling } including Intermediate disposition
- Definitive counseling
  - Informative counseling
  - Directive counseling
  - Advocacy counseling
  - Supportive counseling

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*From Riccardi VM amd Kurtz SM: COMMUNICATION AND COUNSELING IN HEALTH CARE. Accepted for publication.

Each of the skills and concepts which are taught in the unit can be thought of as contributing to one or more of the goals and tasks listed in Table 1. Because it is easy to remember and practical, the conceptual framework enables students to be more aware of just what it is they want to accomplish at any given time during a particular interaction and thereby to be more intentional regarding their own behavior. While the terms used to describe the goals and tasks are fairly straightforward, the types of interaction which comprise the Tri-Level Model (Riccardi, 1977) may require brief definition.

Evaluation involves the gathering of information required for providing definitive counselng. Although some of the information may be derived from previous documents (eg, records of prior hospitalizations), physical examination, laboratory analysis, etc., in almost all clinical settings there is reliance on interviewing.

Definitive counseling involves giving information to or sharing understanding and interpretations with the patient in order to assist and/or advise him in the process of making decisions. There is very little, if any, formal evaluation as such during definitive counseling, although there still may be considerable mutual exchange of information between the clinician and the patient during the definitive counseling process. Because they pertain specifically to the format for teaching information giving skills, the definitions of specific kinds of definitive counseling are presented in the second section of the paper.

Preliminary counseling is best understood as part of the continuum between evaluation and definitive counseling. As information is gathered from the patient information is often imparted to him. For example, the clinician may suggest a tentative conclusion. Or she may have to inquire about something especially sensitive or suggest a laboratory test, either of which may require an explication of the rationale, risks, and tentative consequences. The key is the overlap of information gathering and information giving during this phase of clinical interaction. An understanding of the clinical communication process as a whole is enhanced by appreciation of this interim, preliminary step, the more so because preliminary and definitive counseling may well by undertaken at different time points and often by different clinicians.

Using the concepts and terminology introduced in Table 1, Table 2 (see next page) summarizes the timing and primary emphases of the four parts which together make up the Communication Unit. For a more detailed description of Phase I, see Appendix a. The appendix includes specific objectives, timing and organization of small group sessions, and an observation guide which summarizes the objectives and is used to provide feedback to individual interviewers during small group sessions or for self-assessment. Additional print materials too lengthy for inclusion here define terms, provide rationales, and suggest techniques for accomplishing the objectives. Serving as a reference for both students and preceptors (ie, MD's from the community and faculty who lead the small groups), these materials help to ensure greater similarity regarding what is taught in all small groups. Appendix b details Phase II objectives and organization. Phase III uses large group lecture, discussion, demonstrations, and videotaped interviews as well as individually arranged practice interviews to

Table 2 The Communication/Unit consists of four parts as follows:

	Timing	Primary Focus
Phase I	eleven 2-hour sessions 9/8/82 to 11/25/82	Introduction and overview of clinical communication Conducting a medical interview, especially initiating the interview, gathering information, building relationship (process skills) Contents of the medical interview Peer and self evaluation (Actual patients and role play)
Phase II	four 2-hour sessions spring of first year	Review and refinement of Phase I process and content skills Dealing with psycho-social issues Handling "difficult situations" Giving preliminary information to patients Terminating the interview (3 weeks-Simulated/Actor patients 1 week-actual or role play)
Phase III	four 2-hour sessions late winter or early spring of second year	Review and refinement of Phase I & II process and content skills Giving information to patients -- Definitive counseling (Directive, Advocacy, Informative, Supportive Counseling) Using supportive counseling in specific "difficult situations"
Communication Component of Integrative	part of Integrative Course which runs spring of 2nd year	Review and refinement of Phase I, II, and III process and content skills Giving specific information to patients (ie, definitive counseling) Integrating communication skills, physical examination, medical problem solving, and knowledge base gained in system units

accomplish its ends. Materials (which include videotapes and chapters from the forthcoming book, COMMUNICATION AND COUNSELING IN HEALTH CARE) do not lend themselves to inclusion in this paper. The fourth part of the Communication Unit is presented as a component of the Integrative Course. This three-week course is designed to help students synthesize knowledge gained in individual body systems courses and then apply that knowledge in clinical settings, integrating it with the clinical skills of communication, physical examination, and medical problem solving. (As it is introduced to students elsewhere in the curriculum, medical problem solving includes gathering information and asking questions in order to develop a problem list, testing hypotheses regarding that list, arriving at a diagnosis, and formulating plans or options for treatment and treatment priorities.) Although considerable groundwork is laid earlier, information giving skills and concepts are taught primarily in the last two parts of the Communication Unit.

TEACHING INFORMATION GIVING SKILLS

By this time it should be clear that the format proposed here does not encourage teaching information giving early in the curriculum or as an isolated unit. Indeed, as a prerequisite students should first have considerable training and experience regarding initiating interaction, building relationship, gathering information, and terminating interaction at the end of evaluation interviews. In addition students require a fairly substantial knowledge base with respect to the specific information or counsel they will be giving. For the Communication Unit this latter requirement means that before they focus on how to give counsel to patients, students will have acquired at least some of the medical knowledge necessary to do so. As Table 2 indicates, these prerequsites are fulfilled by waiting until the end of the second year (in the University of Calgary's three-year medical school program) to focus on information giving skills and concepts.

The teaching of information giving skills begins with the assertion that students who have completed Phases I and II of the Communication Unit are already aware of the basic communication skills required for effective information giving -- the basic concepts and skills required for effectively initiating and terminating the evaluation interview, building relationship, and ensuring accuracy, efficiency, and supportiveness in gathering information apply equally when the focus is on information giving. What remains to be done, then, is not so much to learn a new set of skills (although there will be some) as to review and apply relevant "old" skills to information giving in general and to preliminary and definitive counseling in particular. This review also permits significant reinforcement of previously taught skills and concepts. Without periodic reinforcement such skills may well be lost (Helfer, 1970). As indicated earlier, a variety of methods are used to summarize the skills for students, put skills in the context of information giving, and reinforce the importance of continuing to think in terms of the outcomes and objectives which are the focus of a given interaction.

The next step is to explain and establish the value of viewing giving counsel to patients as a four-sided process which includes directive, advocacy, informative, and supportive counseling. We contend that information giving in general and definitive counseling specifically can be learned more efficiently and the skills applied more consistently when the task is broken down into these four types. Definitions, including criteria for determining effectiveness, are as follows (from Riccardi VM and Kurtz SM: COMMUNICATION AND COUNSELING IN HEALTH CARE. Accepted for publication):

Directive counseling involves the clinician giving advice or urging the acceptance of one choice among many alternatives; ie, explicitly directing the patient, essentially deciding for the patient the best course of action. Traditionally, this is what many people have expected from counseling situations -- "Tell me what to do." Criteria for determining the effectiveness of this type of counseling are patient recall, retention, understanding, and compliance.

Advocacy counseling is an important alternative to directive counseling and one which has perhaps been overlooked traditionally. It has two key elements: 1) the promotion of an option or options with a resultant expansion of choice for the patient and 2) the exclusion of compliance as a criterion for effectiveness. Please note our specialized use of the term "advocacy" here. The counseling is guaged effective if there is an expanded freedom of choice (ie, if the patient is at least able to consider an alternative which he/she previously could not), not by whether one particular choice was made. Other criteria for effectiveness include attitude adjustment, patient satisfaction, and patient comprehension and recall. Situations which might call for advocacy counseling include counseling for artificial insemination by donor, amniocentesis, child custody or divorce, exercise and diet therapy for the hypertensive patient who initially would only trust drug therapy.

Informative counseling involves the provision of factual data or explanations about how to do something (rather than whether to do it). There is a minimum of interpretation or opinion. Informative counseling may provide a framework for decision making, but it does not prejudice the decision one way or another. Compliance is again excluded as a criterion for effectiveness. Rather the criteria are patient comprehension, recall, and retention as well as patient satisfaction. Examples include informing patients about a diagnosis and its implications, explaining procedures for using medication, describing alternatives of treatment.

Supportive counseling involves the giving of immediate and/or indirect feedback to the patient to assist him/her in coping with a given situation or series of situations. Its purpose is to put back into manageable perspective an emotional or social influence which the patient perceives to be overwhelming. At one extreme, this counseling modality may become a form of psychotherapy. Short of this, supportive counseling ordinarily serves either as an end in itself or as a means for abetting or enhancing the effectiveness of the other three types of counseling. Emphasis is on clinician compassion, on listening, empathy, acceptance. In the case of supportive counseling what the patient is allowed or encouraged to say is frequently more important than what the clinician says. Although ultimately a decision may be necessary, specific choices in decision making are not

at issue and thus promotion of a given choice drops out and effectiveness cannot be guaged in terms of compliance or even retention. Criteria for effectiveness include patient satisfaction, change in attitude, a feeling of being accepted, and ultimately patient recognition that events can be handled. Relationship building is an important part of supportive counseling, but the two are not synonymous.

The four types of definitive counseling are, of course, not completely distinct entities, but rather overlapping categories on a sort of continuum. Although situations may arise wherein a given patient would be counseled soley in terms of one or the other of the four types, most clinical counseling comprises all four, with varying emphasis on each according to individual needs and circumstances. If the clinician treats each type as entailing somewhat different tactics, goals, and criteria for effectiveness, then he/she can deliberately make adjustments while proceeding with each. Moreover, the clinician, relying on data from his/her evaluation interview, can anticipate the timing and proportion of the entire counseling effort to be spent with each strategy. For example, if a patient were particularly distraught, earlier and longer supportive counseling might be appropriate before moving to informative or advocacy counseling. Finally, this four-alternatives approach moves students away from overemphasizing the directive approach or thinking of compliance as the only legitimate criterion for effectiveness.

To make and illustrate these points, we use lectures, reading material, and discussion of various demonstration videotapes and/or live demonstration interviews. For example, we use a videotape which shows the same two patients (father and daughter) with two different clinicians (Cassata, 1979). One clinician conducts an evaluation interview and the second a supportive counseling session. Additional demonstrations portray each of the other types of definitive counseling sessions. Several basic questions are considered during discussion:

> What type(s) of interaction took place (evaluation, preliminary or definitive counseling)?
>
> With respect to each task (initiating interaction, building relationship, etc.), what specifically did the clinician do to ensure accuracy, efficiency, and supportiveness?
>
> What type(s) of definitive counseling did the clinician focus on?
>
> What outcome(s) did the clinician want?
>
> What specific skills or behaviors did the clinician employ (or attempt) to achieve the desired outcome(s)?
>
> What problems or errors did the clinician have or make?
>
> What would you have done differently to resolve the problems or errors?

A final three-part exercise gives students opportunity to observe and/or practice information giving skills, put the various communication tasks together into a whole, and integrate communication skills with medical problem solving, physical examination, and the knowledge base students have gained by the end of their second year. Working in small groups composed ideally of six students and a preceptor, individual students conduct a three-part interaction with a real or simulated patient (depending on the availability of suitable patients). We are careful to select patients and cases which will challenge students to apply medical knowledge gained in already completed coursework. Preceptors act primarily as resource people for this exercise and can therefore float between two or more groups should this be necessary. Because of the time involved, a different student conducts or directs each of the following:

Part 1: The student conducts an evaluation interview with a patient who has difficulties with which the student has the training to deal. Physical examination is included if appropriate (ie, if a real patient is used rather than a simulated one and if such examination would not be uncomfortable for the patient). If physical examination is not possible, the student will relate what he/she would have done and be told the appropriate findings at the beginning of Part 2. The small group will observe the interview and a second student may take the place of the first student in order to obtain information which the group thinks the first interviewer missed. Each student will provide preliminary counseling and take leave of the patient as is appropriate. The small group including preceptor then engage in a feedback session regarding both content and process skills. When appropriate it is useful to have the patient present to offer feedback at the beginning of this discussion. The evaluation interview is videotaped for use during or after the session.

Part 2: Without the patient present, the small group carries out a problem solving session. The group determines which lab tests are needed and obtains their results from the preceptor (who is provided with the information) or from a computer program or programmed text designed to provide limited information on request. The group formulates hypotheses regarding problem list, tests hypotheses, obtains additional information as needed, and makes a diagnosis. At this point the group is told what the correct diagnosis is. If the group's diagnosis is incorrect, preceptor and group discuss misconceptions, errors, etc. which caused the wrong decision to be made. With the correct diagnosis in mind, students discuss options for treatment and management and make plans regarding how best to counsel the patient. Informative counseling will always be part of the plan to some extent, though the major focus of the counseling session may be advocacy, directive, or supportive counseling or a combination of the types. Again the preceptor will be consulted to comment on appropriateness once the plan is formulated.

Part 3: While the rest of the group observes, one student carries out the planned counseling session with the patient or simulated patient (if necessary, another student from the group can role play the patient at this point). The plan may, of course, be altered during the session at the discretion of the interviewer. A second student may take the place of the first to try an alternative approach, add missing information or correct errors. After the session is completed, the small group including preceptor provide feedback on both content (what was said or done) and process (how it was said or done). The questions that were considered in the discussion of the demonstration tapes (see page 6) are again applied in this setting. However, the words "you" (for self-assessment) or "the student" (for feedback purposes) are put in place of "the clinician". It is quite useful for the patient to join the group to give feedback regarding the counseling and the patient's recall or comprehension of any information given. A videotape recording of the counseling session is made to be used during the feedback session or reviewed later.

Each small group may repeat the exercise with a different patient as many times as is useful; for example, often enough for each group member to interact directly with a patient and receive feedback. The exercise itself is intended to be flexible. Depending on circumstances and objectives, it can be altered in several ways. For example, in Part 1 the evaluation interview may be pre-taped with a volunteer student or experienced clinician, perhaps with some information intentionally omitted. In order to understand the patient's problems and review the skills associated with an evaluation interview, the small group views the videotape, determines what information is missing (if any), and discusses pros and cons of the techniques used by the videotaped interviewer. Using videotape in this way may be necessary when too few patients are available to accomodate the numbers of students involved. In a variation of Part 3, the group may compare its planned or carried out counseling approach with that of an experienced clinician. To do this the group views and discusses a pre-taped counseling session of the experienced clinician working with the same patient that the group has been considering.

During third year clerkships, students have considerable additional opportunity to observe and participate in evaluation of patients, preliminary counseling, and definitive counseling. The format for teaching information giving presented here equips students to plan more intentionally and understand more precisely what it is they are trying to do when they counsel patients. Throughout the Communication Unit, and especially during the integrative component, we emphasize to students that they are learning not only communication skills per se, but also a method for purposefully observing clinician-patient interaction and periodically reviewing and assessing personal skills. This approach to teaching communication in general and information giving in particular provides students with the concepts, skills, and methods to continue systematic and at least partly self-directed improvement of their own skills long after completion of the course.

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*APPENDIX A -- PHASE I

OVERALL OBJECTIVES

These objectives are to be achieved by the end of this specific curriculum unit.

WITH A SIMULATED OR REAL PATIENT OR IN HIS/HER RESPONSE TO A PATIENT-SIMULATION PROBLEM, THE STUDENT-PHYSICIAN WILL DEMONSTRATE HIS/HER ABILITY TO:

1. OBSERVE, accurately, the patient and the patient's environment.

2. Conduct a MEDICAL INTERVIEW in which he/she:

   a) relates to the patient in such a way as to gain his/her trust and co-operation in sharing his/her concerns and in beginning the problem-solving task;

   b) elicits the information required to make an accurate assessment of the patient's presenting complaint;

   c) elicits the information required to make an accurate assessment of the patient's overall bio-psycho-social functioning. This information will include:

      i) history of past health
      ii) family history
      iii) drug and allergy history
      iv) social and personal history, including life situation.
      v) review of systems

   d) recognizes and reacts appropriately to both verbal and non-verbal clues.

3. List the PATIENT'S PROBLEMS from information acquired by observation and by interview.

4. RECORD MEDICAL INFORMATION in the traditional history format

5. Contribute to, as well as utilize, learning opportunities inherent in interaction with patients, peers, preceptors.

*From the Communication Unit, Faculty of Medicine, University of Calgary

SPECIFIC OBJECTIVES

1. Initiating the Interview

The student will:

a) Introduce self and obtain the patient's name in a relaxed, unhurried and confident manner.

b) Clarify expectations for the interview by:

i) Defining for the patient the purpose (e.g. student's education, patient's request, service to patient's physician) and likely length of the interview.

ii) Checking with patients for their expectations. (see objectives 2a and b).

c) Demonstrate an attitude of interest, concern and respect.

d) Demonstrate awareness of the impact of the environment on the interview, including dress, placement of furniture, physical comfort of the patient in terms of light, heat, position of the patient, etc.

e) Demonstrate attentive non-verbal behaviour with regard to:

i) eye contact
ii) movements (including note taking)
iii) facial expression
iv) posture and position
v) voice (rate, pitch, volume, etc.)

f) Develop confidence and become more comfortable in their ability to do the above.

2. Gathering Information

The student will:

a) Identify early in the interview the patient's main problem and reason for presenting at this time.

b) Confirm problem identification with the patient, establish the purpose of the interview to the mutual understanding of the patient and the student, and set the agenda for the interview (contracting).

c) Recall that general observation is an important first step in clinical diagnosis.

i) Recall that observation of the patient is a continu

process - beginning as the patient or observer enters the room, continuing throughout the interview and physical examination and ending as the patient or observer leaves the room.

ii) Recognize that the environmental setting (e.g. lighting, inhibition of behaviour by fear of unfamiliar setting) may have a significant effect on what one observes.

d) Demonstrate the ability to obtain information through observation, in the following areas:

i) Physical appearance of the patient.
ii) General conduct of the patient.
iii) Affect and mood.
iv) Thought processes.

e) Obtain a traditional medical history.

i) history of present illness
ii) history of past health
iii) family history
iv) drug and allergy history
v) social and personal history, including current life situation.
vi) review of systems.

f) Define and demonstrate ability to use the following question and response techniques and to avoid medical jargon.

i) open-ended questions
ii) closed questions
iii) paraphrasing
iv) facilitation
v) repeating
vi) interpretive responses
vii) summation as a response
viii) non-verbal responses including

(a) silence
(b) attending behaviour
(c) empathic behaviour.

ix) supportive response and reassurance

g) Demonstrate the ability to sequence questioning in a logical fashion.

h) Demonstrate the ability to control the interview tactfully.

i) to keep things moving (timing)
ii) to keep the interview on topic.

i) Record the information gathered in a traditional medical history format and recall both the traditional and problem-oriented formats (see Appendix e)

j) Gather information from third parties when appropriate (e.g. confused patient, children, etc.)

k) Strive for accuracy by paraphrasing, internal summarizing, and end summary.

l) Recognize vagueness, omissions and distortions in his/her own communications and in the patients'. Clarify both.

3. Relationship Building

The student will:

a) Continue to demonstrate attentive non-verbal behaviour (see point 1-e).

b) Respond both to the needs of the interview (e.g. timing, headings, etc.) and the needs of the patient (e.g. emotionally laden material cannot be dismissed).

c) Treat the patient as an individual rather than a case or category.

d) Demonstrate acceptance by remaining open to the patient's point of view and refraining from judgemental remarks or actions.

e) Demonstrate empathy.

f) Recognize that one reason patients attend physicians is for support; the student will demonstrate supportive behaviours such as:

i) positive tone of voice
ii) use of verbal reinforcers
iii) nonverbal attentiveness
iv) appropriate use of reassurance
v) sharing of feelings when appropriate.

4. Information Giving

The student will:

a) Summarize the interview to the satisfaction of both himself and the patient (end summary).

b) The student will contract with the patient regarding:

i) subsequent steps to be taken by the physician.
ii) subsequent steps to be taken by the patient.

c) Recognize that information giving is one means of reassuring the patient.

5. Terminating the Interview

a) Ask patient if there are any questions.

b) Take leave appropriately.

6. Difficult Situations

The student will:

a) Be able to maintain control of the interview with talkative patients.

b) Be able to obtain necessary information from excessively quiet patients.

c) Be able to discuss appropriate physician reactions to the following:

i) crying patients
ii) angry patients
iii) socially awkward topics - sex, death, etc.

d) Be able to discuss the role of his own emotions in facilitating or interfering with communication, e.g. anger, embarassment, sadness, etc.

7. Evaluation

With reference to the course objectives the student will:

a) give negative and positive feedback (peer evaluation),
b) receive and utilize negative and positive feedback,
c) evaluate his/her own performance and share this with his/her peers.

LEARNING RESOURCES

1. Scheduled Learning Experiences

a) Whole Class Sessions

i) Wednesday, September 8, 1982 - 1030-1230 hours

Course Orientation/Communication Theory

b) Small Group Sessions*

A. Eight 2-hour sessions, September 15 (or 16) - November 24 (or 25), 1982. Note that two extra 2-hour sesions are scheduled; these may be used in the event of preceptor absence, as additional small group time (e.g. to interview additional patients, deal with specific group interests or concerns, etc. (See Clinical Skills timetable posted on M.I.R. bulletin board.)
Objective 7(a) through (c) is appropriate for each session.

Sessions 1 and 2

These sessions will be used to introduce the student to the small group process and each other. Focus is on initiating the interview as in Enabling Objectives 1(a) through 1(f). Content of interviews will be non-specific and range over problem(s) identification and gathering information about the patient's complaints.

Sessions 3 and 4

Focus will be on the gathering of information as in Enabling Objectives 2(a) through 2(e)-i as well as 3(a) through 3(f). The content of the interviews will focus on the history of present illness.

Sessions 5 and 6

The focus will again be on the gathering of information but as in Enabling Objectives 2(e)-ii-vi, 2(f), 2(g) and 2(h). Also in difficult interviewing situations Objective 5 should be discussed. Content of the interview will include all but review of systems.

Sessions 7 and 8

The focus will be on recording the information gathered as per Enabling Objectives 2(i) through 2(l) as well as 4(a)-5(b) The content will include the social and personal history as well as a review of systems.

*This guide will ensure that the different components of the objectives are covered. The danger of looking at the "whole interview" each session is the tendency to miss specific objectives.

From: Riccardi VM and Kurtz SM: COMMUNICATION AND COUNSELING IN HEALTH CARE.

Communication Unit

Communication Skills - Observation Guide

Describe specific behaviour in the space provided. Include both positive and negative comments.

Student's Name_____ Preceptor's Name_____ Date_____

SESSION	SKILLS	PROCESS COMMENTS	CONTENT COMMENTS
1 & 2	INITIATING INTERVIEW Introduces self/other. Clarifies expectations. Demonstrates respect.		HISTORY OF PRESENT ILLNESS
	Demonstrates attentive behaviour - eg. posture & position, eye contact, voice (pleasant & dynamic). Attends to physical setting and comfort environment of patient.		
3 & 4	BUILDING RELATIONSHIP Responds to needs of interview and needs of patient. Treats patient as an individual not a disease.		HISTORY OF PAST ILLNESSES
	Remains open to patient's point of view. Is not judgemental.		
	Demonstrates attentiveness, acceptance, empathy Listens carefully.		FAMILY HISTORY
	Demonstrates supportive behaviours - positive tone of voice, verbal reinforcers, attentiveness, etc.		
	GATHERING INFORMATION Identifies main secondary problems & reason for presenting now. Verifies with patient.		

SESSION	SKILLS	PROCESS COMMENTS	CONTENT COMMENTS
5 & 6	Avoids jargon Uses appropriate question and response techniques. Open ended questions ☐ Closed questions ☐ Facilitation ☐ Repeating ☐ Paraphrasing ☐ Interpretive response ☐ Silence as response ☐ Summary as response ☐ Supportive response & reasurrance ☐ Listening as response ☐		DRUG AND ALLERGY HISTORIES
			SOCIAL & PERSONAL HISTORY
	Obtains history in logical, easily followed sequence. Makes appropriate transitions.		
	Controls interview (topic and pace).		
	Checks for accurate interpretations; clarifies vagueness, distortions, omissions(own and patients)		
7 & 8	Records appropriate information accurately (written history.		REVIEW OF SYSTEMS
	GIVING INFORMATION Summarizes interview to satisfaction of self and patient - during interview and at end of interview.		
	Contracts with patient re: "next" steps for patient and physician.		
	TERMINATING INTERVIEW Asks for questions. Takes leave appropriately.		
	EVALUATION Provides peer description and self description (positive and negative)		

Appendix b

CLASS OF 1985

COMMUNICATION UNIT, PHASE II - Objectives and Procedures

Dates:

April

Time:

Same as for Phase I preceptor groups
Wednesday 10:30 - 12:30; Thursday 8:30 - 10:30; Rms. G602 to G607

Objectives:

Phase II core document and observation guide are the same as for Phase I. The four small group sessions of Phase II focus on:

a) Review and refinement of interviewing process and content skills introduced in Phase I. Students will conduct 30-minute interviews with simulated patients. (See Procedures, next page).

b) Giving information to patient (eg. summary, contracting re potential next steps, reassurance), terminating the interview, dealing with psycho-social issues, and handling "difficult situations". See yellow sheet, "Enabling Objectives" 4, 5, 6, and 7.

For the first three sessions of Phase II (see below) students will interview simulated patients, that is, actors trained to portray specific roles. The use of simulated patients allows us to choose medical problems for which students have some background and can in fact provide some counsel. Generally speaking, cases involve systems already covered in the curriculum (Reproductive, Cardiovascular, RE and Respiratory). Thus, students can a) apply newly acquired content knowledge while gathering information and b) make attempts at giving some information to simulated patients with the assurance that inadvertent misinformation will not be given to "real" patients. In other words, students are freer to experiment and make mistakes with simulated patients. The use of simulated patients will also provide students with opportunity to confront a variety of "difficult" situations (e.g. anger, garrulousnous) which would occur rarely if at all with volunteer patients. Finally, students will have better opportunity in Phase II to explore psycho-social aspects of the history or present case -- because simulated patients are playing a role, students are free to pursue psycho-social issues which some students may have felt were too personal or embarrassing to raise with "real" patients.

c) Introducing the written medical record (see information in appendices of core document and in Procedures below).

Procedures

SIMULATED PATIENT INTERVIEWS (primary focus)

Simulated patients (i.e., actors and actresses) will be present for interviews the first three weeks. The fourth week is reserved for interview with preceptor-provided patients*, role playing within the group, discussion of medical record keeping or such other activities as the group deems appropriate.

Due to the fact that we are using actors and actresses to portray simulated patients, you are asked to comply with the following schedule for the first three weeks:

First half hour of session — interview simulated patient

Second half hour of session -- discuss interview (simulated patient will be available for comment during this discussion

Third half hour of session — second interview

Fourth half hour of session -- discuss second interview (simulated patient will be available for comment)

This schedule allows each student to conduct and receive feedback for one 30-minute interview with a simulated patient and to observe and comment on five other such interviews. Continue to use the Observation Guide to write down feedback regarding both process and content of the interview. Preceptor groups can obtain additional Observation Guides from the desk in Room G610. Feedback should be given in keeping with the objectives presented earlier in this memo.

WRITTEN MEDICAL RECORD (secondary focus)

Please note that the intent of this assignment is to a) assist students in assessing their strengths and weaknesses regarding the content of the interview and b) introduce the basics of writing traditional medical records.

Each student will write up at least one medical record based on his/her interview with a simulated patient and hand in the medical record to his/her preceptor for critique. Preceptors, please include in your critique comments on completeness and accuracy of content, clarity, and organization. Return written record and comments to students (not to unit managers). Students may find it useful to write up a medical record based on any of the interviews they observe in their group and then to compare write-ups with the student who conducted the interview. It is advisable to write histories "immediately", basing them on recall and brief notes made during the interview, rather than after looking at your videotape recordings.

Evaluation of Phase II

PRELIMINARY EVALUATION

To provide students with a summary of their progress to date, preceptors are asked to fill in an Observation Guide for each of their students which summarizes specific strengths and points out weaknesses which the student needs to work on correcting before the certifying examination in May. Students should have an opportunity to see and discuss this evaluation with their preceptors before the evaluation is turned in to the Unit Managers on the last day of Phase II. Part of the last session may be used for such discussion. Unit Managers will keep these evaluations on file, but it should be noted that these summaries do not constitute a certifying examination.

CERTIFYING EXAMINATION

The certifying examination for the Communication Unit will be held on May 18, 1982. Appendix h of the core document explains that examination.

Resource Material

Same as Phase I. Please review the core document objectives and appendices before the first session of Phase II.

If you have any questions or comments regarding Phase II or the Communication Unit in general, please contact Suzanne Kurtz (Education Tower 1112, 284-7362) or Cathy Heaton (ACC, 283-7531).